

2018 Medicare PPO Plans for Erie County

TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	MVP Healthcare 1-888-280-6205		Independent Health (716)635-4900		BlueCross/BlueShield 1-800-248-9296					
		Well Select with Part D		Medicare Passport Advantage PPO		Forever Blue PPO Focus		Forever Blue PPO Value		Forever Blue PPO 751	
PREMIUMS	\$134.00	\$73.00		\$87		\$61		\$136		\$198	
Deductible	\$183			\$0		\$0		\$0		\$0	
		IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
PCP Visits	20%**	\$15	\$60	\$0	\$25	\$20	35%	\$15	35%	\$5	25%
Wellness Exam	\$0	\$0	\$0	\$0	40%	\$0	\$0	\$0	\$0	\$0	\$0
Specialty Visits	20%**	\$50	\$60	\$45	\$75	\$40	35%	\$35	35%	\$27	25%
Outpatient Mental Health	20%	\$40	\$60	\$40	40%	\$40	50%	\$40	50%	\$40	50%
Outpatient Substance Abuse	20%**	\$50	\$60	40%	40%	50%	50%	50%	50%	50%	50%
Outpatient Surgery	20%**	\$300/\$600	40%	300/\$350	40%	\$300/\$375	35%	\$250/\$325	35%	\$200/\$275	25%
Emergency Care	20%**	\$75	\$75	\$80	\$80	\$80	\$80	\$80	\$80	\$80	\$80
Urgent Care	20%**	\$60	\$60	\$65	\$65	\$65	\$65	\$65	\$65	\$65	\$65
Ambulance Services	20%**	\$200	\$200	\$250	\$250	\$250	\$250	\$250	\$250	\$200	\$200
Durable Medical Equipment	20% Medicare Approved	20%	40%	20%	50%	20%	50%	20%	50%	20%	50%
Prosthetic Devices	20%	20%	40%	20%	50%	20%	50%	20%	50%	20%	50%
Cardiac Rehab	20%	36session=\$50	Not Covered	36sessions=\$15	36sessions=40%	\$15	35%	\$15	35%	\$15	25%
X-Rays	20%**	\$60	\$60	\$35	40%	\$50	35%	\$50	35%	\$40	25%
Diagnostic Services	20%	\$20-20%	40%	\$150	40%	\$150	35%	\$150	35%	\$75	25%
Lab Services	\$0	\$20	40%	\$0	40%	\$5	35%	\$5	35%	\$5	25%
Radiation Therapy	20%	20%	40%	20%	50%	\$60	35%	\$60	35%	\$5	25%
Chiropractic Care	limited coverage 20%**	\$20	Not Covered	\$20	50%	\$20	35%	\$20	35%	\$20	25%
Medically Necessary Foot Care	20%** (medical limits apply)	\$50	\$60	\$45	\$75	\$50	35%	\$35	35%	\$27	25%
Routine Foot Care	Not Covered	\$50	\$60	Not Covered	Not Covered	\$40	35%	\$35	35%	\$27	25%
P.T., O.T. and Speech Therapy	20%**	\$40	\$60	\$15	40%	\$25	35%	\$25	35%	\$25	25%
Inpatient Hospital	\$1,340 deductible	\$450/day days 1-4 \$0/day days 5+	40%	\$250/day days 1-7 \$0/day days 8+	40%	\$270/day days 1-7 \$0/day days 8+	35%	\$250/day days 1-7 \$0/day days 8+	35%	\$205/day days 1-7 \$0/day days 8+	30%
Inpatient Mental Health*	\$1,340 deductible	\$315/day days 1-5 \$0/day days 6+	40%	\$250/day days 1-6 \$0/day days 7+	50%	\$260/day days 1-6 \$0/day days 7+	35%	\$270/day days 1-6 \$0/day days 7+	35%	\$270/day days 1-6 \$0/day days 7+	30%

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		Well Select with Part D		Medicare Passport Advantage PPO		Forever Blue PPO Focus		Forever Blue PPO Value		Forever Blue PPO 751	
PREMIUMS	\$134			\$87		\$61		\$136		\$198	
Deductible	\$183.00			\$0		\$0		\$0		\$0	
		IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Skilled Nursing Facility	\$0/day days 1-20 \$167.50/day days 21-100	\$0/day days 1-20 \$160/day days 21-100	40%	\$0/day days 1-20 \$167.50/day days 21-100	40%	\$0/day days 1-20 \$167.50/day days 21-100	35%	\$0/day days 1-20 \$167.50/day days 21-100	35%	\$0/day days 1-20 \$164.50/day days 21-100	30%
Home Health Care	\$0	\$0	40%	\$0	40%	\$0	35%	\$0	35%	\$0	25%
Mammograms	\$0	\$0	\$0	\$0	40%	\$0	35%	\$0	35%	\$0	25%
Bone Mass Measurment	\$0	\$0	\$0	\$0	40%	\$0	35%	\$0	35%	\$0	25%
Colorectal Screening	\$0	\$0	\$0	\$0	40%	\$0	35%	\$0	35%	\$0	25%
Flu, Pneumonia & Hepatitis B	\$0	\$0	\$0	\$0	40%	\$0	35%	\$0	35%	\$0	25%
Dialysis	20%	20%	20%	10%	10%	20%	20%	\$30	\$30/20%	\$20	\$20/20%
Prescription Drugs	20% Part B Covered only No Part D	Copays \$1/\$11/\$47/50%/25%, \$400 Deductible, 20%-Part B Drugs	40%-Part B Drugs	Copays \$0/\$20/\$47/50%/33%, No Deductible, 20%-Part B Drugs	Copays \$0/\$20/\$47/50%/33%, No Deductible, 40%-Part B Drugs	Copays \$10/\$15/\$42/\$94/27%, \$290 deductible for Tiers 3-5, 20%-Part B Drugs	Copays \$10/\$15/\$42/\$94/27%, \$290 deductible for Tiers 3-5, 35%-Part B Drugs	Copays \$4/\$10/\$42/50%/33%, No Deductible, 20%-Part B Drugs	Copays \$4/\$10/\$42/50%/33%, No Deductible, 35%-Part B Drugs	Copays \$2/\$8/\$42/\$94/33%, No Deductible, 20%-Part B Drugs	Copays \$2/\$8/\$42/\$94/33%, No Deductible, 25%-Part B Drugs
Vision Services	20% + for 1 pair glasses/frames/contact lens after cataract surgery 20% + coverage for retinopathy exam 1 per year for diabetics	\$50 Eye Exam 20% Post-cataract Surgery Eyewear	\$60 Eye Exam 40% Post-cataract Surgery Eyewear	\$0 Eye Exam \$200/yr Eyeglasses Allowance	\$75 Eye Exam \$200/yr Eyeglasses Allowance	\$40 Eye Exam \$100/yr Eyeglasses Allowance	35% Eye Exam \$100/yr Eyeglasses Allowance	\$35 Eye Exam \$100/yr Eyeglasses Allowance	35% Eye Exam \$100/yr Eyeglasses Allowance	\$27 Eye Exam \$100/yr Eyeglasses Allowance	25% Eye Exam \$100/yr Eyeglasses Allowance
Hearing Services	20%**	\$50 Exam, \$699-\$999 per aid/per year	\$60 Exam,100% aids	\$0/\$45 Exam; \$599-\$899 per aid/per year	40% Routine Exam	\$40/\$45 Exam, \$699-\$999 per aid/per year	\$45/35% Exam, \$699-\$999 per aid/per year	\$35/\$45 Exam, \$699-\$999 per aid/per year	\$45/35% Exam, \$699-\$999 per aid/per year	\$27/\$45 Exam, \$699-\$999 per aid/per year	\$45/25% Exam, \$699-\$999 per aid/per year
Diabetic Training and Supplies	20%	20%	40%	Training \$0, Supplies \$10	Training 40%, Supplies 40%	\$0	50%	\$0	50%	\$0	50%
Dental Coverage	limited coverage 20%**	Not Covered	Not Covered	\$0: 2 routine cleanings, exams/bitewing x-rays/yr; full mouth/every 3yrs	\$20/50%: 2 routine cleanings, exams/bitewing x-rays/yr; full mouth/every 3 yrs	Not Covered *Optional Dental Coverage Available	Not Covered *Optional Dental Coverage Available	Not Covered * Optional Dental Coverage Available	Not Covered * Optional Dental Coverage Available	Routine exam/cleaning \$27 *Optional Dental Coverage Available	Routine exam/cleaning 25% *Optional Dental Coverage Available
Max out of Pocket		\$6,700	\$10,000	\$6,700	\$10,000	\$6,700	\$10,000	\$6,700	\$10,000	\$6,700	\$10,000
Full LIS		\$29.40		\$48		\$22		\$97		\$159	
Full LIS & EPIC		\$29.40		\$9		\$22		\$97		\$159	

2018 Medicare PPO Plans for Erie County

TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	United Healthcare Medicare Complete Choice 1-800-555-5757								Today's Options 1-866-249-8668			
		Plan 1		Plan 3		Plan 4		Essential No RX		Advantage Plus 150A		Advantage Plus 550B	
PREMIUMS	\$134	\$17		\$47		\$77		\$0		\$105		\$19	
Deductible	\$183	\$0		\$0		\$0		\$0		\$0		\$0	
		IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
PCP Visits	20%**	\$10	\$50	\$10	\$50	\$5	\$50	\$10	\$50	\$0	\$10	\$10	\$25
Wellness Exam	\$0	\$0	0-40%	\$0	0-40%	\$0	0-40%	\$0	40%	\$0	\$10	\$0	\$25
Specialty Visits	20%**	\$45	\$75	\$35	\$75	\$25	\$75	\$45	\$75	\$25	\$35	\$35	\$60
Outpatient Mental Health	20%	\$30/\$40	\$35/\$45	\$30/\$40	\$35/\$45	\$30/\$40	\$35/\$45	\$30/\$40	\$35/\$45	\$30	30%	\$40	30%
Outpatient Substance Abuse	20%**	\$30/\$40	\$35/\$45	\$30/\$40	\$35/\$45	\$30/\$40	\$35/\$45	\$30/\$40	\$35/\$45	\$30	30%	\$40	30%
Outpatient Surgery	20%**	20%	40%	\$295	40%	\$250	40%	20%	40%	\$150-\$200	30%	\$250-\$300	30%
Emergency Care	20%**	\$80	\$80	\$80	\$80	\$80	\$80	\$80	\$80	\$80	20% Worldwide Coverage	\$100	20% Worldwide Coverage
Urgent Care	20%**	\$30-\$40	\$30-\$40	\$30-\$40	\$30-\$40	\$25-\$40	\$25-\$40	\$30-\$40	\$30-\$40; \$80	\$35	\$35	\$35	\$35
Ambulance Services	20%**	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$300	\$300	\$300	\$300
Durable Medical Equipment	20% Medicare Approved	20%	50%	20%	50%	20%	50%	20%	50%	20%	30%	20%	30%
Prosthetic Devices	20%	20%	40%	20%	40%	20%	40%	20%	40%	20%	30%	20%	30%
Cardiac Rehab	20%	\$20	40%	\$20	40%	\$20	40%	\$20	40%	\$15	30%	\$40	30%
X-Rays	20%**	\$14	\$21	\$14	\$21	\$14	\$21	\$14	\$21	\$15	30%	\$15	30%
Diagnostic Services	20%	20%	40%	20%	40%	20%	40%	20%	40%	20%	30%	20%	30%
Lab Services	\$0	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$0	30%	\$0	30%
Radiation Therapy	20%	20%	40%	20%	40%	20%	40%	20%	40%	30%	25%	20%	30%
Chiropractic Care	limited coverage 20%**	\$20	\$75	\$20	\$75	\$20	\$75	\$20	\$75	\$20	30%	\$20	30%
Medically Necessary Foot Care	20%** (medical limits apply)	\$45	\$75	\$35	\$75	\$25	\$75	\$45	\$75	\$35-limitations	30%-limitations	\$50-limitations	30%-limitations
Routine Foot Care	not covered	6visits/yr=\$45ea	6visits/yr=\$75ea	6visits/yr=\$35ea	6visits/yr= \$75ea	6visits/yr=\$25ea	6visits/yr=\$75ea	6visits/yr=\$45ea	6visits/yr=\$75ea	\$35	30%	\$50	30%
P.T., O.T. and Speech Therapy	20%**	\$40	\$75	\$35	\$75	\$25	\$75	\$40	\$75	\$15	30%	\$40	30%
Inpatient Hospital	\$1340 Deductible	\$395/day days 1-4 \$0/day days 5+	\$500/day days 1-20 \$0/day days 21+	\$360/day days 1-4 \$0/day days 5+	\$500/day days 1-20 \$0/day days 21+	\$295/day days 1-4 \$0/day days 5+	\$500/day days 1-20 \$0/day days 21+	\$395/day days 1-4 \$0/day days 5+	\$500/day days 1-20 \$0/day days 21+	\$500	\$300/day days 1-7 \$0/day days 8-90	\$295/day days 1-5; \$0/day days 6-90	\$300/day days 1-7 \$0/day days 8-90
Inpatient Mental Health*	\$1340 Deductible	\$395/day days 1-4 \$0/day days 5-90	\$500/day days 1-20 \$0/day days 21-90	\$360/day days 1-4 \$0/day days 5-90	\$500/day days 1-20 \$0/day days 21-90	\$295/day days 1-4 \$0/day days 5-90	\$500/day days 1-20 \$0/day days 21-90	\$395/day days 1-4 \$0/day days 5-90	\$500/day days 1-20 \$0/day days 21-90	\$500	\$300/day days 1-7 \$0/day days 8-90	\$295/day days 1-5 \$0/day days 6-90	\$300/day days 1-7 \$0/day days 8-90

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TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	United Healthcare Medicare Complete Choice 1-800-555-5757								Today's Options 1-866-249-8668			
		Plan 1		Plan 3		Plan 4		Essential No RX		Advantage Plus 150A		Advantage Plus 550B	
PREMIUMS	\$134	\$17		\$47		\$77		\$0		\$105		\$19	
Deductible	\$183	\$0		\$0		\$0		\$0		\$0		\$0	
		IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Skilled Nursing Facility	Days 1-20 \$0 Days 21-100 \$167.50/day	\$0/day days 1-20 \$160/day days 21-62 \$0/day days 63-100	\$250/day days 1-40 \$0/day days 41-100	\$0/day days 1-20 \$160/day days 21-62; \$0/day days 63-100	\$250/day days 1-40 \$0/day days 41-100	\$0/day days 1-20 \$160/day days 21-54 \$0/day days 55-100	\$250/day days 1-40 \$0/day days 41-100	\$0/day days 1-20 \$160/day days 21-62 \$0/day days 63-100	\$250/day days 1-40 \$0/day days 41-100	\$0/day days 1-20 \$150/day days 21-100	\$0/day days 1-20 \$200/day days 21-100	\$0/day days 1-20 \$165/day days 21-100	\$0/day days 1-20 \$250/day days 21-100
Home Health Care	\$0	\$0	50%	\$0	50%	\$0	50%	\$0	50%	\$0	30%	\$0	30%
Mammograms	\$0	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	30%	\$0	30%
Bone Mass Measurment	\$0	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	30%	\$0	30%
Colorectal Screening	\$0	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	30%	\$0	30%
Flu, Pneumonia & Hepatitis B	\$0	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	30%	\$0	30%
Dialysis	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	30%	20%	30%
Prescription Drugs	20% Part B Covered only No Part D	Copays \$3/\$12/\$47/ \$100/26%, \$350 Deductible; Tiers 3-5, 20%-Part B Drugs	Copays \$3/\$12/\$47/ \$100/26%, \$350 Deductible Tiers 3-5, 40%-Part B Drugs	Copays \$3/\$12/\$47/ \$100/28%, \$225 Deductible Tiers 3-5, 20%-Part B Drugs	Copays \$3/\$12/\$47/ \$100/28%, \$225 Deductible Tiers 3-5, 40%-Part B Drugs	Copays \$3/\$12/\$47/ \$100/31%; \$100 Deductible, Tiers 3-5, 20%-Part B Drugs	Copays \$3/\$12/\$47/ \$100/31%, \$100 Deductible, Tiers 3-5 40%-Part B Drugs	Part D=not covered; Part B=20%	Part D=not covered; Part B=40%	Copays \$0/\$5/\$35/\$75/33%, No Deductible, 20%-Part B Drugs	Copays \$0/\$5/\$35/\$75/33% , No Deductible, 30%-Part B Drugs	Copays \$2/\$7/\$37/\$90/33%, No Deductible, 20%-Part B Drugs	Copays \$2/\$7/\$37/\$90/33 % , No Deductible, 30%-Part B Drugs
Vision Services	20% + for 1 pair glasses/ frames/contact lens after cataract surgery 20% + coverage for retinopathy exam 1 per year for diabetics	\$20 Eye Exam \$0 Post-cataract Surgery Eyewear	\$45 Eye Exam 40% Post-cataract Surgery Eyewear	\$20 Eye Exam \$0 Post-cataract Surgery Eyewear	\$75 Eye Exam 40% Post-cataract Surgery Eyewear	\$20 Eye Exam \$0 Post-cataract Surgery Eyewear	\$75 Eye Exam 40% Post-cataract Surgery Eyewear	\$20 Eye Exam \$0 Post-cataract Surgery Eyewear	\$75 Eye Exam 40% Post-cataract Surgery Eyewear	\$0 Eye Exam \$20 Post-cataract Surgery Eyewear	30% Eye Exam 30% Post-cataract Surgery Eyewear	\$0 Eye Exam \$20 Post-cataract Surgery Eyewear	30% Eye Exam 30% Post-cataract Surgery Eyewear
Hearing Services	20%**	Exam=\$10;2aids/yr=\$330-\$380ea	Exam=\$75;2aids/yr=\$330-\$380ea	Exam=\$10;2aids/yr = \$330-\$380ea	Exam=\$75;2aids/yr = \$330-\$380ea	Exam=\$5;2aids/yr = \$330-\$380ea	Exam=\$75;2aids/yr = \$330-\$380ea	Exam=\$10;2aids/yr= \$330-\$380ea	Exam=\$75;2aids/yr= \$330-\$380ea	\$20	30%	\$20	30%
Diabetic Training and Supplies	20%	\$0-20%	40%	\$0-20%	40%	\$0-20%	40%	\$0-20%	40%	0-20%	30%	0-20%	30%
Dental Coverage	limited coverage 20%**	Not Covered * Optional Dental Coverage	Not Covered * Optional Dental Coverage	Limited \$0 * Optional Dental Coverage	Limited 50% * Optional Dental Coverage	Limited \$0 *Optional Dental Coverage	Limited 75% * Optional Dental Coverage	Not Covered * Optional Dental Coverage	Not Covered * Optional Dental Coverage	Comprehensive	Comprehensive	Comprehensive	Comprehensive
Max out of Pocket		\$6,700	\$10,000	\$6,700	\$10,000	\$5,400	\$10,000	\$6,700	\$10,000	\$3,400	\$3,400	\$6,700	6,700
Full LIS		\$0		\$18		\$41.30		No RX					
Full LIS & EPIC		\$0		\$18		\$41.30		No RX					